Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MARCONI PHYSICAL PERFORMANCE TESTING
4251 FM 2181 #230-512
CORINTH TX 76210

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-10-1131-01

MFDR Date Received
OCTOBER 20, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The denial for this FCE states provider is not in compliance with the MFG. See MFDR decision M4-07-6401-01. This MFDR decision was obtained in 2007; however the last revision of the Texas Department of Insurance (DWC) rules on TDI's website is 10/13/08 and there is no mention of this MFDR decision..."

Amount in Dispute: $612.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has denied payment in full for these services coded as 97760 functional capacity evaluation (FCE) because the health care provider is not in compliance with the Medical Fee Guideline."

Response Submitted by: Texas Mutual Insurance Company, 6210 E Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2009	FCE Testing	$612.00	$612.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Workers' Compensation Specific Services.
3. 28 Texas Administrative Code §134.203 sets out reimbursement for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 152 – Payer deems the information submitted does not support this length of service, number of units billed exceeds number of units performed. Provider is not in compliance with the MFG. See MFDR decision M4-07-6401-01. See enclosed explanation of EOB dated 09/03/2009.
- W1 – Workers Compensation state fee schedule adjustment.
- 892 – Denied in accordance with DWC rules and/or Medical Fee Guideline.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- 891 – The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the requestor support the FCE in accordance with DWC rules and the Medical Fee Guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §134.204(g) the following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements: (1) A physical examination and neurological evaluation, which include the following: A) appearance (observational and palpation); B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities; (D) vascular integrity; (E) neurological tests to detect sensory deficit; (F) myotomal strength to detect gross motor deficit; and (G) reflexes to detect neurological reflex symmetry. (2) A physical capacity evaluation of the injured area, which includes the following: (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes. (3) Functional abilities tests, which include the following: (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing); (B)hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices; (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and (D) static positional tolerance (observational determination of tolerance for sitting or standing).

   Review of the submitted FCE report finds the documentation supports the services billed. The requestor has documented a start time of 12:00 pm and a finish time of 4:00 pm. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

   - CPT Code 97750-FC – (53.68 ÷ 36.0666) x $27.46 x 16 = $653.92. The requestor is seeking $612.00
2. Review of the submitted documentation finds that the requestor is due reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $612.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $612.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.